PUBLIC HEALTH

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EDITORIAL

Local Authorities, Health and Disease

It is difficult to avoid clichés and platitudes in discussing the value of preventive medicine. The Scottish report, entitled "What Local Authorities Can Do to Promote Health and Prevent Disease,"* states that prevention is certainly better than cure, and that the importance of preventive medicine has been greatly underrated in the last 20 years! Yet perhaps it is salutary for local authorities and their medical officers to be sharply reminded of "the job to be done." We are emerging from a period when a gloom has been cast over the value of the work of local authorities, and when a few Medical Officers of Health wondered what could justify their further existence; a feeling which was sometimes responsible for a lethargy and a pessimism wholly unjustified by the real needs of the people. It is evidently still necessary to remind our masters that illness is very expensive. Some clinicians have taken the airy attitude that it is hardly worth while preventing many illnesses—"If it comes along, we'll soon cure it." Health promotion and disease prevention have fallen on hard times.

But let us look at the many remaining problems. Nearly three-quarters of all deaths in the "under 45" group are due to preventable causes. All observers agree that there is a large amount of unnecessary illness among people of all ages. In some small aspects of medical and social problems we appear to have been too successful; hence further problems have arisen—*e.g.*, in adding years to life by better care of the aged, we have raised more problems than we can at present solve. Then, again, the survival of some of the premature, handicapped or otherwise unfit babies who might have died involves comprehensive schemes of public health activity. The increased incidences of psychosomatic disease and of the various degenerations challenge us with new tasks. And, let it be asked, do we know the people of this country as we should, their special health and social problems? As the report says in considering the reduction of death-rates, while much has been accomplished "the thought that fully one-fifth of all deaths occur in children and young adults is a sobering one." Nearly three-fourths of all these deaths fall into five groups—death from infection, infant death, death from violence, from respiratory conditions and from diarrhoea and enteritis.

"If parents were educated to regard whooping-cough and measles as serious illnesses and to seek early medical advice, there would be fewer deaths from these conditions". With regard to stillbirths and infant deaths there are more of these per thousand of the population among the poorer classes than among the well-to-do.

How may we bring the rates for the country as a whole nearer to the level of the highest social class? As we all know, a high proportion of preventable accidents occur in the home. Medical Officers of Health may be able by surveys to establish common causes and work out ways of prevention. Early diagnosis and modern methods of treatment might do much to prevent deaths from pneumonia and bronchitis. Attention to smoke abatement is also important; the educative influence of a progressive local authority can do much in this field. Most of the deaths from diarrhoea and enteritis occur in babies under one year. The encouragement of breast feeding and anti-fly campaigns would go far to prevent such deaths. Similarly, sustained campaigns for safe food and hygienic food handling might completely abolish enteric fever and dysentery.

Of course, it is "never the right time" to make big changes. Undoubtedly the shortage of money and manpower to-day is a deterrent. Many of the proposals suggested in the report will need more health visitors, more home helps; more this-and-that. But ideas cost nothing, and there are opportunities, for example, in the health educational field where much advantage may be gained with little or no out-of-pocket expenditure. The report recommends authorities to select for immediate action these projects which can be carried out with little or no additional cost of staff. At the same time, they should prepare plans for bringing into operation fundamental measures designed to save the use of expensive hospital beds, and to improve the health of the people.

Determined preventive measures can surely help in a stronger attack on the grave problem of tuberculosis. Such simple points as control of indiscriminate spitting, attention to ventilation and arrangements for sleeping, still need attention. So do after-care and early diagnosis. In the reduction of non-respiratory tuberculosis, the production and distribution of "safe" milk is of supreme importance.

The findings of the School Health Service provide an annual jerk to complacency. In 1948–49 over 40% of school entrants were found to be suffering from defects. Many of these could have been simply prevented by better ante-natal and child care. The commonest ailments among children and adults are infections, skin diseases, respiratory tract conditions and injuries.

A high percentage of illness is caused by mental and emotional disorders; one-third of patients are mental

* Prepared by the Standing Advisory Committee on Local Authority Services of the Scottish Health Services Council. (Price 6d.) H.M. Stationery Office, Edinburgh and London. 1951.

patients. Here the report outlines a huge task. In the improvement of mental hygiene a secure and happy home is of primary importance. Instruction to mothers in the problems of child upbringing can be given at child welfare and ante-natal clinics, and in some areas group discussion is held for the mothers, pooling their experience. For the elderly, social clubs, suitable hostels and the right type of houses have their place in reducing the tremendous toll of mental illness.

It is to be hoped that this report will remind some local authorities both North and South of the Border of the need for wider vision and of the basic principles of good local government. Some authorities might even become better employers ! Parsimonious treatment in the past has caused many practitioners and consultants to " look down " on local government. Some local authority members have had a small-mindedness which has unfitted them for public service in this new age. Officers have found it very much easier to secure shorter working hours or some costly concession to large groups of employees than to obtain a pittance for a public health measure of real importance. Many authorities have rightly demanded social security for their workers ; but have the members the social *maturity* necessary for progressive public health action ? As a start and to encourage local authority members, we can think of no better investment than to send copies of this pamphlet to each member of the health committee, as well as to these members and officers responsible for financial control. This Scottish report, costing a modest " saxpence," might well be sent also to all Jeremiahs who doubt the future of the public health service. Rather is it better to be reminded, in the words of the advertisement of a well-known beverage, " Just think of what you can do ! "

We congratulate all those responsible for a timely report which, at a time when so much frustrates us, brings us a message that we must plan new measures to meet new problems and intensify our activities to the *nth* degree.

The Late Dr. E. H. Wilkins and School Health

The recent suggestions that the time has arrived for the transfer of both Maternity and Child Welfare and School Health Services to the Hospital Services or to the General Practitioner service is naturally giving rise to much controversy. It may well be that the general practitioner with the preventive outlook and a desire to practise social medicine could find his place in the ordinary sections of the School Health Service, if he has the available time. Reliable guides are now being published showing the changing outlook of the workers in this field since the inception of the service in 1907. In those early days the service was concerned mainly with the recognition and treatment of defects. Gradually as the service developed defects were diagnosed at progressively earlier stages and treatment was given with greater benefit. Possibly, even in this journal, it is as well to recall that the title School Medical Service was changed significantly to the School Health Service in 1945. The present concept then is concerned not only with the prevention and treatment of illness and defects but also with the promotion of health.

Dr. E. H. Wilkins was a well-known exponent of this modern practice of school medicine. He was singularly fitted for this role by his training, outlook and experience, and above all, by his abiding devotion to the welfare of children. After holding the appointment of Director of School Hygiene, New Zealand, he served for many years as Assistant School Medical Officer in Birmingham. During this period he gave expression to his ideas of the changing practice of social medicine in general, in articles and letters which appeared frequently in the journals. He initiated, or continued in a lively manner, discussions in a style characteristic of his origin. Often a rebel, he was never nonplussed if his ideas were at variance with the accepted local or national pattern. Deeply interested in sociological problems, he was the secretary of a committee in Birmingham which investigated and published, at the outbreak of the war, a report relating to nutrition and size of family.

Happily Wilkins, with his wide background of actual experience, conceived the idea of setting out his knowledge for the benefit of his colleagues and all who were interested in school medicine. Unfortunately, however, he was unable to see the completion of his project as he died after a short illness in 1946. This was indeed a tragedy, but the blow was softened as the draft of the book, although unfinished, had reached a stage where other hands could take up the thread. Accordingly, the School Health Service Group of the Society decided to make itself responsible for the completion of the work, not only as a memorial to Dr. Wilkins, who was a member of the Group, but also because of a strong belief in the value of the book.

The book has now been published with the title " The Medical Inspection of School Children,"* which, it is understood, was chosen by Dr. Wilkins. The editors, however, in the preface, indicate that the book deals with all the wider implications of the subject, stressing its practical nature in considering all the issues, social as well as medical, which arise when judgment is being passed upon a child's health. The controversy over the value of periodical medical inspection was debated only recently and this early statement is encouraging to those who appreciate the modern character of these inspections.

Wilkins wished primarily to draw attention to those subjects which he felt were not given adequate attention in in the medical curriculum, concerned as it is more with disease than healthy functioning of the body. School medicine should be concerned with achieving and maintaining health and ensuring that every child reaches its maximum potentiality. Quite rightly he appeals to school doctors to keep this goal in view, insisting on the highest efficiency Naturally a full account is given of the value of the sociological background. There can be no question regarding the importance of social medicine and no longer is the child considered in isolation from the family background. The enquiry into family circumstances, however, must be made with discretion as several unfortunate incidents have clearly demonstrated. Yet the school nurse should be able to assist through personal knowledge of the home environment of all the children.

Although the standard of cleanliness is attacked, the difficulties in the way of attaining the ideal are recognised. Incidentally this lack of facilities in many homes was sympathetically discussed in " Our Towns," which reported on the unsavoury conditions of some of the children evacuated from urban areas. Wilkins pleads for a new approach to the teaching of personal hygiene in the schools, with the suggestion that success will be gained through integrations with general education.

A helpful chapter is concerned with the use and purpose of past medical history and information obtained from the school nurse, teacher and education welfare officers. Sir George Newman stressed the need for examining the attendance register and, more recently, Bransby's specific enquiry† reinforced the value of this procedure. It is of great interest, therefore, to note that Wilkins considered regularity of attendance a most helpful guide.

The complex subject of growth and body-measurements is fully discussed. The conclusion reached is that the most direct help from such information for an individual child is obtained from repeated measurements suitably charted. It is generally agreed that an isolated record of a child's height and weight does not give useful information at the time of examination. Some mention might have been made, however, of the " springing-up " and " filling-out " periods of a child's developments. Wilkins had given much thought to musculo-skeletal condition in relationship to posture and physique and here we have the fruits of his closely pursued studies. There are some excellent photographs of actual faulty conditions but, in view of the involved descriptions

* (Pp. 232, 21 illustrations. Price 16s. net.) London : Baillière, Tindall & Cox, Ltd. 1952.

† Bransby, E. R. A Study of Absence from School. (1951.) *Med. Offr.*, **86**, 223 and 237.

and the details given for further investigation of the subject, the addition of some simple diagram would have enhanced this important section. With reason, the need for collaboration between physiotherapists, remedial gymnasts and the teachers of physical training is stressed. This is in line with the discussions which have taken place recently between representatives of these groups at national level. Although the value of physical education to the mind as well as to the body is unquestioned, at the same time, exponents of the subject are advocating a cautious and critical approach to the claims of remedial physical exercises.

Examination of the feet has only comparatively recently been included in the survey examination, yet Wilkins many years ago was writing authoritatively in the journals on conditions found in school children, and the need for the adoption of preventive measures. During the war, orthopaedic surgeons drew attention to the foot defects found in many young persons serving in the Forces. Conferences dealing with foot health have accordingly pleaded for regular foot inspection of school children by persons with special knowledge and training. The information in this book, based on practical considerations, should go far to meet this requirement.

A complete medical examination of school children naturally includes an assessment of the health of the teeth and adjoining structures. Doctors, whose knowledge in this sphere tends to be slight, should welcome the sections on teeth and jaw deformity and dental irregularity. The various theories on the causes of dental caries are usefully set out for easy reference. Eyes and vision, ears and hearing are dealt with briefly, the discussion being limited to aspects to which special attention should be drawn. The principles of correct frame-fitting should be welcome, as school medical officers have to give advice on this subject. A brief discussion on hearing and reference to the various types of tone-deafness should stimulate the reader to acquire further knowledge of these important topics. High-frequency tone-deafness is also mentioned in the short account on speech as a cause of faulty articulation.

Inspection of the whole body is advocated whenever diagnosis of a skin condition is required. Useful hints are given in skin problems in school children while the incidence of skin diseases, together with their comparative frequency, are also listed.

A conservative outlook is maintained on the much-debated question of the treatment of tonsils, which will repay careful consideration. Also in the section on respiration is included a note on the non-operative and preventive treatment of respiratory ailments. Paediatricians are concerned over the incidence of upper respiratory catarrh among children and attempts at prevention should be very much the concern of the school doctor. Wilkins set great store by ultra-violet radiation for this condition. Incidentally he was an advocate for this form of treatment for many other conditions.

Special aspects of the alimentary and cardio-vascular systems of importance to school medicine are briefly discussed. The significance of abnormal or adventitious heart sounds is of such import that the note of this defect should be adequately amplified. In this section the author mentions the colour of the lips as being a reliable guide to haemoglobin content. But is it? Recent investigations indicate that there is very little correlation between the actual haemoglobin content of the blood and the colour of mucous membranes. An appendix deals with vital capacity and its measurement by means of the spirometer. The significance of vital capacity is fully discussed and this estimation should be of interest to school medical officers who employ tests of physical efficiency.

So far consideration has been given in the main to bodily health but a further appendix is given up to mental disability. This is good but far too brief. Mental hygiene is of such importance that this chapter could be usefully expanded in any future edition.

This review can but draw attention to the special value of the book not only to school doctors but to all who work with children. They will find much to stimulate and to interest them. Although the appendices were written by persons other than the original author, the book can be regarded as a testament to a life given to the welfare of children.

Bristol's Health Centre

Professor R. H. Parry has been one of the leaders of thought about the health centres envisaged by the National Health Service Act, and the report by a special committee of the Society which he chaired in 1947 was for a long time the only well-thought-out document in existence on the subject. It is therefore all the more striking that he, with his deputy, Dr. Wofinden,* has become convinced by hard experience in developing the first health centre in his own city that the day of "comprehensive" health centres is still far ahead of us and indeed that the best approach may be to see that general practitioners have satisfactory houses of their own to practise from, while local authorities continue to provide separate premises for the traditional purposes of maternity and child welfare and school health service. They suggest, indeed, that there must be a period of experiment with the few health centres which exist in order to form a firm opinion whether the cost of these institutions will be justified by an improved standard of practice and a better service to the patient.

The Bristol health centre described by Wofinden and Parry, like the others in existence or under construction, with the exception of that at Manchester, serves a housing estate which has been doctorless or under-doctored. The Knowle West Estate was built between the wars and has hitherto been served only by branch surgeries, so inadequately that in 1939 the corporation provided a minor ailments centre for all ages, staffed by two resident nurses, as an ancillary to Southmead Municipal Hospital, five to six miles away. From the appointed day in 1948 the District Nursing Association became responsible and three nurses lived there and gave some 1,500 treatments a week. This service has now been transferred to the new centre.

In May, 1948, negotiations began for development of the health centre, and have involved four Government departments, four committees of the city council, the executive council, the Regional Hospital Board, Board of Governors, Working Committee of General Practitioners and, since July, 1951, a Joint Advisory Committee of the L.H.A., L.E.C. and L.M.C. The centre is regarded as a temporary one, is used jointly by L.H.A., L.E.A. and L.E.C., and is run without a manager or resident doctor, nurse or caretaker, and without dentists, pharmacy or *x*-ray. A further economy is that the M. & C.W. and school clinics use the same accommodation as the general practitioners but outside surgery hours. Four houses have been rented near the centre for the nursing superintendent, for three nurses working in the centre, for three district nurses and for a midwife and two pupils. Six general practitioners use the centre more or less as their branch surgery. No financial arrangements have been made for group practice as some of the doctors are in partnership with others not associated with the centre. The rents to be paid by the doctors through the L.E.C. have been fixed for only one year and may then be revised; they represent only a fraction of the weekly maintenance cost of the centre, nearly £200. The capital cost of the centre is £16,000, a very reasonable figure in the light of present-day costs and for the accommodation provided (six general practitioner suites and a minor surgery unit).

Regarding the high maintenance costs, it is pointed out that the ancillary help is largely responsible—"In effect one is buying time for the general practitioner" to be given, it is hoped, to the better care of patients. The fact that 30 to 40 such centres would be needed for Bristol as a whole makes the authors look to alternatives other than health centres, either the leasing of land to general practitioners so that they could build their own houses with surgeries, or building of doctors' houses with surgeries by the local authority and leasing them at an economic rent. The

* Bristol's New Health Centre. Wofinden, R. C., & Parry, R. H. *Lancet* (June 25th, 1952), I, 1297.

former would cost the local authority nothing, and the latter's cost (£8,300 for two such houses) would bring back rent ; but the local authority would still have to face the capital cost of separate M. & C.W. and school clinics.

However, this venture must be welcomed by all who wish to see experiments of various sorts in bringing together general practitioners and the public health team under one roof. Moreover, Drs. Parry and Wofinden have added a valuable contribution to the literature of this new field.

Mortality from Cancer

A study of the evolution of mortality from cancer and other malignant tumours during the 20th century has been published by the World Health Organisation.* This report, which covers the period from 1900 to 1950, analyses information concerning many countries in Europe, South Africa, Canada, Chile, the U.S.A., Uruguay, Japan, Australia and New Zealand. Referring to "formidable difficulties" in undertaking this analysis, the author, Dr. M. Pascua, W.H.O. Director of Health Statistics, stresses the need for great caution when trying to draw definite conclusions from his report. He quotes differences in population figures, mortality data, medical certification of deaths, and many other factors, including advance in age of the population. Thus, in Denmark, out of every 1,000 inhabitants, the proportion of persons aged 60 and over has increased from 99 at the beginning of this century to 131 in 1949, in France from 124 to 163, in England and Wales from 75 to 159, and in the United States from 64 to 116.

The report points out that at the beginning of the century many countries showed less than 5% of all deaths attributable to cancer and malignant tumours (Sweden, with the highest percentage, did not reach 8%). By 1947, in great contrast, most of the nations studied had one in every seven to nine deaths reported as due to cancer, with the percentage exceeding 10% in many cases. Denmark and the Netherlands surpassed 16%.

The report analyses cancer mortality by sex, site of tumour and age groups in 23 countries and concludes with the general remarks that there are very pronounced differences in cancer mortality in the different countries studied, and that racial influences have been adduced by various scientists as a partial explanation of these divergencies, and that cancer mortality "has clearly increased in practically all the nations included in this review."

This study confirms that deaths from cancer of the respiratory system have increased very rapidly in most nations, and at a decidedly greater speed in males. The largest rise has occurred in the last 20 years, and cancer of the lungs attains the highest percentage in this category. In this connection the report draws attention to the investigation carried out in London by Hill and Doll for the Medical Research Council (1950) which indicated that smoking is an important factor in the cause of cancer of the lung. Discussing the "extraordinary rise recorded in mortality from cancer of the lung," Dr. Pascua points out that other reasons have been suggested, including prolonged exposure to industrial emanations and automobile exhaust fumes.

Other points to which Dr. Pascua draws attention are that mortality from cancer of the uterus has been stationary, or has dropped in the course of this century, whereas the death-rates for cancer of the genital organs in both sexes rose significantly over the same period, and recorded mortality from cancer of the breast in females has increased considerably, despite its easy diagnosis and the relatively optimistic prognosis if diagnosed and treated early.

The proportion of deaths attributed to "senility" or coded by "ill-defined or unknown causes" at ages when cancer mortality becomes important has shown a sharp reduction in most countries in recent decades ; this should be kept in mind when studying cancer statistics, as improved diagnostic methods are obviously closely connected.

Dr. Pascua concludes by stressing the need for better statistics in the study of cancer and expresses the hope that improvement will result from the new movement set up in several countries to establish cancer registration systems for elucidating many unknown aspects of its epidemiology.

* *Epidemiological and Vital Statistics Report*, Vol. V, Nos. 1 & 2. Although dated January–February, 1952, this report was not published until May.

The XIth International Dental Congress

In collaboration with the Fédération Dentaire International and with the British Dental Association acting as hosts, the XIth International Dental Congress was held in London from July 19th to 26th, 1952, at the Royal Festival Hall. International Dental Congresses are held at five-yearly intervals in member countries of the Federation and only the youngest of practitioners are likely to have the opportunity of attending during their lifetimes another such assembly. Adjudged by any standard the Congress must be acclaimed a great success. Over 4,000 dentists attended and of these a large proportion were from overseas. The British Dental Association are to be congratulated on the excellence of the arrangements.

Considerable importance was attached to the problem of the prevention of dental disease. It early became clear that the Americans have lost none of their enthusiasm for fluoridation of communal water supplies as a means of controlling and reducing to manageable proportions the incidence of dental decay. In their view any change in the nation's dietetic habits towards a diminution in the intake of sugars and refined carbohydrate is improbable and impractical and no doubt they are right in a country where foodstuffs are entirely unrationed and free from control. As Dr. J. W. Knutson, U.S.A., aptly reminded his audience, the English had once earned for themselves the nickname of "limeys" from their sailors' habit of drinking lime juice for the prevention of scurvy. They had not then waited for a complete knowledge of the therapeutic whys and wherefores of its action before taking advantage of its preventive properties. Why therefore wait, he stressed, until a full knowledge of the action of fluorine on teeth is forthcoming before taking advantage of its undoubted value when over 3,000,000 people in the U.S.A. have been consuming throughout their lives water containing as much, and in many cases considerably more than the recommended artificially induced concentration of fluoride, without harmful results. Dr. R. D. Ribble, of New Jersey, U.S.A., showed a film and gave details of the present dental status of the Tristan da Cunha islanders, who have long been known as a remarkably dental-caries-free community as opposed to a similarly isolated group on Pitcairn island, where caries was rife. He established the fact that their drinking water contains 0·9 parts per million* of fluorine and that their fluorine intake is still further boosted by the sea food which forms an important element in their diet and by the fact that sea-weed is used to add humus to their fields. As regards the topical application of fluorides to the surfaces of the teeth it has been established that perfectly sound enamel remains unaffected and that only where it has been rendered spongy by the action of acid is the fluoride absorbed, showing that only in the earliest stages of dental caries is fluorine applied in this way effective.

The Oral Hygiene Exhibition held in conjunction with the Congress was good and contained an exhibit for which the Dental Officers' Group of the Society was in part responsible. The details given of the advances made in their public dental services in Norway and Denmark, as set out in the exhibits from those two countries, were extremely impressive, as was the United States exhibit which was confined to the one subject, "Fluoridation." One wonders if those who oppose "fluoridation" on the grounds of the doubtful ethics of "mass-medication" are aware of the many different chemical substances already added to water supplies for their improvement for domestic use.

The Congress was under the Presidency of Dr. E. W. Fish, Chairman of the Dental Board.

* The recommended concentration in the U.S.A. is 1 to 1·5 p.p.m. of fluorine.

LEPROSY

With Particular Reference to Conditions at Present Pertaining in the British Isles*

By R. G. COCHRANE, M.D., F.R.C.P., D.T.M. & H.
Adviser in Leprosy to the Ministry of Health

I am mindful of the privilege which has been conferred on me in the request to address the Metropolitan Branch of this Society. I trust that this paper of mine will assist in a better understanding of the disease, and help Medical Officers of Health in their desire to play their part in the general process of education of the public in the question of leprosy.

To review the history of leprosy, its decline and fall in Great Britain is a task beyond my powers, even if I had the time for such an undertaking. Such a work has been admirably accomplished, first by a former Chief Medical Officer of Health for England in the Sydenham Lectures, published in 1895, and subsequently by that accomplished Director of Medical Services, General Sir William Macarthur, in his lectures on "Old-Time Diseases." Suffice it to say that leprosy appears to have existed in the British Isles over a period of approximately 1,100 years (A.D. 638 to A.D. 1798), the last indigenous case of leprosy dying in 1798 in the Shetland Islands.

There have been many theories as to the cause of the decline of leprosy in England. Sir George Newman rejected both the theory of contagion, as well as that of heredity, and attributed the spread of leprosy to dietetic factors, and its decline in this country to social improvement in the life of the people, and to a complete change in the poor and insufficient diet, agricultural advancement, improved sanitation and land drainage.

It is now generally accepted that leprosy is a disease of very low virulence, and it is also generally held that while infection is by contact of a healthy person with an infected case, the average adult is practically non-susceptible. Personally, I am of opinion that leprosy died out in this country because there came a time when it was no longer possible for children to become infected, and that leprosy cannot maintain itself as an endemic disease apart from child infections. In consequence of this, although the number of cases in this country may have doubled, and perhaps trebled, in the last 30 years, of all the cases recently reported no case has been traced to an infection from a patient with leprosy in Britain.

I should like to spend much more time than is now possible in discussing the fascinating question as to how a person acquires leprosy. If, therefore, the remarks I am about to make appear to be didactic and dogmatic, I trust I shall be forgiven ; space and time alone forbid lengthy explanations for the views which I now present. Recent work in India, particularly from Bombay, indicates that the acquirement of leprosy is through skin-to-skin contact, either directly by personal contact with an infective case, or indirectly through clothing, bedding, etc. Further, there is considerable evidence to show that, as in tuberculosis, so in leprosy, there is a silent phase of the disease in which the *M. leprae* is introduced in the body, but there are no clinical signs. It appears that in the adult, at any rate, in many instances these bacilli are destroyed and leprosy as a clinical condition never develops. If the person is a child, or is a susceptible adult, the *M. leprae* may multiply, but in order to invade the body the organisms pass into the subcutaneous nerve plexuses of the skin, and from these break out into the deeper parts of the corium, and clinical leprosy then appears. If this is the case, it suggests that one of the reasons why the *M. leprae* has not been cultivated as yet is because it may have to become established in nerve tissue before there can be a general spread of the organism throughout the skin.

The question will at once be asked—"How does the *M. leprae* get into the skin of a healthy person ? Is an abrasion necessary ?" This does not seem to be essential. In my opinion three factors are essential before there is a danger of infection—(1) *M. leprae* demonstrable in the skin in relatively large numbers by standard methods of examination ; (2) transference of these mycobacteria to a healthy person ; (3) the individual susceptibility of the person infected—slight in adults and greater, much greater, in children. It is surmised that not more than 3 to 5% of the adult population is liable to show signs of the disease if infected.

In a country like Britain these conditions of infection are difficult to provide, and the chances of the disease being passed on to another person are minimal, if not negligible.

The Present Position in England and Wales

I shall now pass on to the present position with regard to leprosy, particularly in England and Wales. As there is no evidence of indigenous leprosy in this country the disease, therefore, must be introduced by those who either have lived abroad and have returned—soldiers, civil servants, missionaries, traders, etc.—or are immigrants from countries where leprosy is endemic. Up to date about 100 cases have been reported from England and Wales. There are probably some 20 cases not yet reported, and there are others not detected. It may, therefore, be stated that the number of cases in England and Wales is probably approximately 150. As the Ministry of Health in England has no jurisdiction in Scotland, the number of cases in that country is not definitely known, but so far as information is available it is exceedingly small, probably not more than a dozen cases.

While the overseas population (Dominion and foreign) and the Anglo-Indian community, which has migrated from India to England, account for over 50% of the cases, it must not be imagined that leprosy arises only in these communities. Neither must it be thought that the disease can only turn up in large towns. Wherever men and women have been in the tropics physicians must be on the watch for cases of leprosy, particularly where the signs, dermatological and neurological, indicate some obscure disease, which has not shown itself amenable to standard methods of therapy.

Owing to more rapid communications, the ease of travel, unsettled political and economic conditions, the number of persons seeking asylum in this country from European, Asiatic and African countries, where leprosy is endemic, must consequently be greater than ever. This inevitably means a gradual increase in the number of cases of leprosy over the next decade, and it is not beyond the bounds of possibility that in this way the numbers may reach 300. It will be at once remarked, "But such people have no business entering the country !" Unfortunately, it is not so easy to detect leprosy as it is to discover smallpox among immigrants and others entering the country. There are three reasons for this difficulty in diagnosis—(1) the patient may be in the silent phase of the disease, and develop leprosy many years after he has entered the country ; (2) the patient may be unaware of his condition, and not suspect his trouble until some overt symptom arises ; and (3) even though a patient is aware that he has leprosy he may seek, if a British subject, domicile in this country because of intolerable and harsh rules pertaining in the country from which he comes. Leprosy is difficult to detect to those unfamiliar with the disease, and short of establishing an "Ellis Island" for all immigrants entering this country, it would be impossible to expect to discover cases.

The fact must be accepted that we have leprosy in Britain, and we now have to seek means by which the disease can be effectively, humanely and reasonably dealt with, without any panic. Neither should we be unduly disturbed by this fact. One thing is certain, no measures involving compulsion to isolate, resulting in victimisation of the patient, are ever

* Address to the Metropolitan Branch, Society of Medical Officers of Health, London, March 14th, 1952.

likely to succeed. For such harsh and mediaeval measures drive the disease underground, and deprive patients of their rightful due—adequate treatment—and result in misery and terror, increasing the possibilities of further infection, and creating the very impression one seeks to avoid—that leprosy is so horrible a disease that the least said about it the better.

It has to be borne in mind that any member of the public, who is under the National Health Service Act, is entitled to treatment, and, if necessary, specialist care. Therefore to deprive persons of such facilities, who have acquired leprosy through no fault of their own, and, in a certain number of instances, while in service of the Crown, is a manifest injustice. As there is now a relatively effective treatment for leprosy which will arrest the disease, it is the right of every person to be given such treatment as will relieve and cure his malady. Further, now that a successful treatment is available, every effort should be made, through plastic and orthopaedic surgery, to remedy the deformities and mutilations caused by leprosy in its advanced stage, for no citizen should remain crippled or disfigured if there are means to get rid of the gross stigmata of disease.

Notification and the Public Attitude to Disease

For these reasons, therefore, the Ministry of Health, on advice of specialists, decided to declare leprosy a notifiable disease. It must be stated here, quite emphatically, that this step was not taken because it was considered that leprosy has now become a menace to public health. It is, therefore, necessary to avoid any undue publicity being given to leprosy. The people of this country have still an elemental fear of leprosy, and when primitive terror seizes a population, humanity and consideration go out of the window. I can cite instances where, as a result of well-meaning but injudicious application of health measures, a patient's life has become intolerable. We all know the reaction of the ordinary man in the street. We know by the way the word "leper" is widely used how, even in professional circles, there must be a strong aversion to the disease, built up from prejudices and traditions handed down through ages of time. Tuberculosis and syphilis have passed through the era of terror, and there is now greater enlightenment; but leprosy still is shrouded in mediaeval horror. Here I would like to pay a tribute to those hospital authorities who have co-operated in the organisation of treatment for such cases as may have been discovered. There is no panic. There is a straightforward common-sense approach to the disease.

The only way to overcome the terror of leprosy is through education. It would be unwise to emphasise too prominently the fact of leprosy in this country, but wherever possible the elementary facts of this disease should be available to the public, *e.g.*, pamphlets which give very briefly and clearly what leprosy is. It should also be generally known that, like tuberculosis, much leprosy is relatively innocuous and may disappear spontaneously. It cannot be too strongly emphasised that in order to view leprosy aright one's whole attitude towards the disease must be altered. Therefore, such words as "leper," "clean," "untainted" should find no part in one's vocabulary, because they indicate a conception which belongs to the Middle Ages.

It is interesting to note in this connection that special nouns have been used largely for diseases with a social stigma, *e.g.*, syphilitic, lunatic, consumptive, leper. Not until the medical profession ceased to call those who were mentally afflicted lunatics, and those who had tuberculosis consumptives, did a fresh outlook arise. It is believed, therefore, that if the medical profession would refuse to refer to people with leprosy as "lepers," then a saner attitude towards this disease would arise, and those with leprosy would no longer be shunned unnecessarily and outcast from the community with little hope of ever being re-established even though their disease, in many instances, is innocuous, or when they have been rendered free from infection.

It has been frequently asked, "If there is no need to be fearful concerning leprosy, what is the explanation of the widespread dread of the disease?" In European countries this dread can be traced to the attitude adopted as the result of measures taken against leprosy in Biblical times. It should here be explained that what is described as leprosy in the Bible is, I believe, a generic name for a group of diseases. Some authorities doubt the existence of true leprosy in Old Testament times. The health laws of the ancient people of Israel are among the most perfect in the world. Because the people of Israel were firmly convinced that they were a chosen people "separated unto the Lord," nothing with a permanent blemish was permitted within the camp. Therefore, all mutilating, all infective, all unsightly conditions were placed "without the camp." When the word Zaraath, which probably covered a large number of diseases, was translated, it was referred to as leprosy. Hence a sense of horror was attached to the name, and a disease which does not deserve the opprobrium showered upon it became synonymous with something which conveyed a sense of fear, dread and horror.

Facilities for Treatment

As this is an address to Health Officers, and is an attempt to place leprosy within its proper perspective, I have made very little reference to treatment. It would, I believe, be of interest to you to know what facilities there are for treatment in this country. In the first place, when a case is suspected the practitioner usually seeks the advice of a consultant, generally a dermatologist. It is one of my duties to get into touch with the doctor who is treating the case, and ascertain whether he is desirous of expert help. As a result I have personally seen the large majority of the cases and advised as to treatment. In certain cases operative measures have been necessary and it has been possible, in most instances, to get surgical help. By and large, because the patients can be treated individually, the therapy which has been advised is oral administration of the parent sulphone—diamino-diphenyl-sulphone (D.D.S.). In a few instances aqueous sulphetrone (50% solution) intramuscularly has been preferred. The therapeutic dose of the sulphones has now been shown to be so low that the original toxic reactions which were seen are much less common. The maximum dose of D.D.S. is 400 mg. twice a week, taking about four months to reach this, or 1·5 grammes sulphetrone given parenterally twice a week.

Facilities now exist for the adequate treatment of leprosy patients in this country and it is our duty to ensure that this treatment is carried out effectively and efficiently, without any publicity. In this way it is hoped that within a matter of five years the number of active cases of leprosy will be substantially reduced, and that the public will learn to look upon it as a disease not to be feared, and extend to the sufferer all the sympathy he deserves.

The Ministry of Health has a Home near Redhill. The purpose of this Home is to make available expert treatment for those cases who need special attention. It is unfortunate that there has been so much local feeling shown in Reigate, for the fears of the people are quite unfounded. Leprosy, like tuberculosis, needs institutional facilities for treatment. The proximity of such a home constitutes no danger to the inhabitants in the vicinity, and it is hoped that, as public opinion becomes more educated with regard to this disease, this agitation will cease.

I have tried, inadequately I fear, to give a picture of leprosy as it exists to-day in England. I have made a plea for more understanding of the patient and his disease, and I trust that I have in some way assisted in the task which has been set—to bring to every patient in this land, who has acquired leprosy, adequate care and treatment, and conditions of domicile in which he is not perpetually living on the edge of a great fear—the discovery of his disease. If this address has helped materially towards this end I shall be well satisfied.

SOME VIEWS ON THE MATERNITY SERVICE*

By G. GORDON LENNON, CH.M., F.R.C.O.G., M.M.S.A.,

Professor of Obstetrics and Gynaecology, University of Bristol

I am one of the new breed of whole-time professors, in fact, you may regard me at the moment as in the ante-natal period of life as a professor. I may say I am suffering similar difficulties to that encountered by the foetus. I have a struggle for nutrition and I am at times liable to suffer from placental insufficiency. I get depressed by delays and I react as does the foetus with vigorous movements. My maternal association largely consists in getting committees to accept new ideas and there is not always adequate maternal adjustment. For example, I had to "sell" with all the salesmanship at my command the idea of an emergency obstetric service ("Flying Squad") to Bristol. I believe that the Flying Squad should go out not only for cases of haemorrhage but also for those of eclampsia and bring the patient into hospital under "Avertin" sedation, thereby preventing the usual fit in the ambulance. So far as the rest of the country is concerned that is not very much a new idea, but it took just one year to get it agreed to by committees and actually put into operation. The total duration of my gestation is therefore very uncertain. My obstetrician is the University of Bristol and I should like to pay tribute to the facilities already granted, and to the Vice-Chancellor, Sir Philip Morris, for his help and encouragement. I may carry this analogy further and say that my midwife is Professor Parry, known to you as the Medical Officer of Health for Bristol, and his pupil midwives Dr. Wofinden and Dr. Walker. To all of them I extend my thanks for encouragement and help. The general practitioners' Local Medical Committee has also been acting the part of midwife so far as I have been concerned, and, indeed, has been anxious to keep the "new child" in order. Whether I shall be a spontaneous or aided "birth" is a matter for the future and dependent on my rate and extent of growth.

Divided Control

I have interested myself very much in the present maternity service in Bristol. Indeed, I have gone so far as to criticise certain aspects of it and I have suggested improvements for the future in an article already published in the *Bristol Medico-Chirurgical Journal* (1952). Some of the points mentioned there require reiteration and amplification.

All over the country the Maternity Service is suffering from triple control: (1) Local Authority; (2) Hospital; (3) Local Executive Council. These three authorities have been in the past perhaps too interested in the advancement of their own particular ideas and too little in co-operation. The hospitals have been too autocratic and the general practitioners and midwives too antagonistic for real co-operation, a state of affairs largely brought about by the introduction of the National Health Service. Concentration has been too much on financial reimbursement rather than on service for the patient. Here I would quote Baird (1951), "The problem is not simply whether midwifery should be in the hands of doctors, midwives or specialists, or whether confinement should be at home or in hospital, but what will give the best results from the point of view of the patient and community at large."

Hospital—General Practitioner—Midwife Co-operation

I believe I can incorporate general practitioners and midwives into the Maternity Service by encouraging them in the view that they are part of a team consisting of consultant and themselves. The individual practitioner can work with the midwife in his district and also as clinical assistant to the consultant of his choice, not only by referring those cases which he desires the consultant to see, but by filtering all his cases through the consultant clinic at least twice, early in the ante-natal period and again at the 36th week, even if he is delivering the patient in her own home or in a general practitioner hospital or home. In other cases the consultant may reciprocate by getting the general practitioner to supervise the ante-natal care of some of his cases that are eventually to be delivered in hospital for medical or social reasons. Consultants may not like this because it would mean more work for them, but with the facilities available to them in the form of registrars this would largely be a matter of delegation of responsibility. Its advantages are that patients would have contact with hospitals and practitioners would have done for them blood tests and ancillary examinations, for example, *x*-ray of the patient's chest if required. Another advantage would be that a few patients could be booked for hospital at an earlier date, due to the discovery of an obstetrical indication which might have escaped the general practitioner. I have seen a woman marked with pelvic contraction booked for home delivery. The hospital would thus be supervising (if I may use the term) those patients booked for hospital and those for domiciliary confinement. Should anything go wrong during domiciliary confinement the hospital specialists would not be strangers either to doctor, midwife or patient. In the same way the general practitioner could "supervise" midwives' cases and the midwives would have the benefit of the practitioner's opinion which might obviate some visits to the hospital clinic.

The use of this word "supervise" is causing heartaches so far as general practitioners are concerned, but if there is to be real co-operation and good care of the patient then it is essential. A general practitioner—Dr. Rogers (1952)—has written: "Their (general practitioners and midwives) own competence would be no less for having the added assurance that should more serious complications supervene specialist obstetric help would be available without delay and without the necessity of transporting a tired or gravely shocked patient from home to hospital." Dr. Rogers is pleading for general practitioner beds attached to hospitals, but his reasons are no less cogent in regard to hospital and domiciliary co-operation.

Toxaemia of pregnancy is now the major cause of maternal mortality and prematurity. Until the aetiology of this condition is discovered only careful ante-natal care will prevent unpleasant sequelae. In one of the hospitals within my care already this year three women have died from the effects of toxaemia of pregnancy and in each case there was grave lack of care, sometimes on the part of the patient because she did not attend regularly, but more often on the part of the general practitioner. In this connection midwives could be valuable to the general practitioner by chasing the patients if they failed to attend for an appointment and by carrying out frequent blood pressure and urine tests. This is one of the very real ways in which midwife and general practitioner co-operation could be most valuable.

Local Authority Clinics

Local authority clinics staffed by "ante-natalists" do good work but there is need for association of these clinic doctors with the hospital set-up. This could be arranged by making them clinical assistants and giving them facilities for hospital attendance and teaching. Many of these "ante-natalists" attend once a week at my weekly department meeting when the treatment of interesting cases in the hospital is discussed.

These clinics must not be isolated units working only with the hospital and midwife. They must work intimately with the patient's doctor. In the past in some areas there has been antagonism between clinic and general practitioner, the latter complaining that too often he has had no idea his patient was pregnant.

Education of the Patient

The changing pattern and conduct of midwifery service has laid emphasis on education of the patient. I have been accustomed for some years now to give 10- to 15-minute talks to the patients assembled at the clinic. These six talks in a recurring series deal with :—

* Address to the West of England Branch, Society of M.O.H., Bath, May 3rd, 1952.

1. The need for and importance of ante-natal and post-natal clinics.
2. The three stages of labour.
3. Relief of pain.
4. Relaxation and exercises.
5. Care of the baby in the first month.
6. Care of the breasts and breast feeding.

By this means the patient is taken more into confidence and, I believe, her fears are alleviated.

The educational side should not be overlooked at the post-natal clinic. Helpful advice on birth control at this time can be invaluable.

Clinical Notes and Personal Card

In large cities it is difficult for all patients to be seen at the ante-natal clinic attached to a particular hospital. There must be supplementary clinics at some distance away. The problem of a patient's notes being immediately available on her admission to hospital is a difficult one. Until recently in Bristol it had been the custom for the patient's notes to be photographed at about the 37th week, and that copy was sent to the hospital. After the patient's admission the full notes were procured. This meant that valuable notes made in the last week or two were not available and very often the photostatic copies themselves were not to hand. Various remedies were considered to overcome this difficulty mostly remedies necessitating quite an expenditure of money.

For a few years before the war I was accustomed to issuing a personal card to the patient and this scheme is now being tried again in Bristol. The fact that the patient carries about with her a short summary of her notes (information can usually be summarised in a way not to upset the patient should she read it) means that her clinic notes can be seen at any time by midwife, general practitioner or consultant. I found by experience that patients very seldom forgot their cards and if they did relatives brought it up to the hospital very quickly. This personal card is printed on both sides.† It is a single card which is folded in two and enclosed in an envelope. On the outside of this envelope are instructions to the patient to carry the card with her in her handbag at all times and there is also the address of a hospital or clinic to which the card should be returned if found. It is not intended that this card should replace the full clinic notes but that it should be a supplement to these, containing information of immediate importance to anyone who has to see the patient, particularly in emergency, even after confinement.

The Future

Elsewhere (1952) I have suggested that I believe there will be an end of domiciliary maternity service. This does not mean that I am of the opinion that all confinements should take place in hospital. It does mean, however, that the setting aside of a room in a dwelling-house should no longer be considered a proper place for confinement. Units should be provided where the general practitioner working with the midwife can perform his work in properly equipped surroundings, and when an emergency arises facilities for treating the patient will be readily available. When statistics are quoted with regard to domiciliary midwifery it is too often forgotten that cases ending in difficulty are immediately transferred to hospital and if the woman should die there it is a maternal death in the hospital statistics. Very often this applies also to the babies. Domiciliary midwifery is an inheritance of the past, but that does not mean that it is the best method. The greatest antagonism to this idea will be from midwives and not from the doctors. They will see in this the giving up of a mode of life which has been theirs for centuries. But it does not mean that their services will no longer be required. They will be as necessary as before in staffing these units. A National Service should provide such arrangement.

† The items on the front side of the card are age, L.M.P., E.D.D., blood group, previous history, obstetric history, summary of early pregnancy examinations, details of family doctor, consultant and midwife, baby's birth weight, date of birth, sex, feeding ; then labour, puerperium, discharge examination (urine B.P.), post-natal examination, remarks. The other side deals with summary of pregnancy to 30th week, notes from 30th week onwards.

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DENTAL CARE FOR THE PRIORITY CLASSES

With reference to our editorial of June last which quoted a letter by the Minister of Education on dental care provision by local authorities, it has been suggested that the subsequent joint circular issued by the two Central Departments (Ministry of Health 22/52, Ministry of Education, 254, dated June 30th, 1952) should be reproduced in this journal for the information of dental members and others interested. The circular reads as follows:—

National Health Service and School Health Service

DENTAL CARE OF EXPECTANT AND NURSING MOTHERS AND CHILDREN OF SCHOOL AGE AND UNDER

As the Authority are aware, the National Health Service Act, 1952, which received the Royal Assent on May 22nd, imposes certain charges for dental treatment provided under Parts II and IV of the National Health Service Act, 1946, in addition to the charges for dentures laid down in the National Health Service Act, 1951. These charges do not apply to treatment (or dentures) provided by local health authorities in pursuance of their duty under Section 22(1) of the National Health Service Act to make arrangements for the dental care of expectant and nursing mothers and children under school age. For dental treatment, including dentures, provided by local authorities, the authorities have no power to make a charge except for the replacement of dentures necessitated by lack of care on the part of the owner (see paragraph 5 of Circular 100/48 of June 18th, 1948). The duty which local education authorities have under Section 48(3) of the Education Act, 1944, to make arrangements for securing the provision of free dental treatment for pupils in schools maintained by them is also unaffected by the new Act.

The dental care of children and expectant and nursing mothers calls for special measures which can satisfactorily be provided only by a comprehensive dental service of inspection and treatment which, for school children, can be secured by an adequate dental service forming part of the educational system and closely associated with school routine and, for expectant and nursing mothers and children under school age, by a service forming part of the local health authorities' general arrangements for the care of mothers and children. In the case of school children, inspection in school and the offer of treatment at a centre which a child can attend in company with his fellows, contributes largely to the acceptance of treatment by many children who would otherwise fail to obtain systematic dental care.

The Ministers of Health and Education realise that owing to the great demands with which the general dental services have had to deal in the last few years, local health and local education authorities have been unable to procure sufficient dentists to expand their own dental services to meet adequately the special needs of mothers and children and, indeed, that these services generally have lost dental staff. Some authorities, however, have recently succeeded in obtaining more dental staff, and it is the Government's hope that the fall in the demand for treatment under the general dental service which has already become apparent, and the exceptional importance and the urgent needs of the priority dental services of the local health and education authorities, will encourage still more dentists to work in these services. The Ministers consider that the time is now ripe, therefore, for authorities to make a new intensive and continuous effort to build up the staff of their dental services. They are aware that, in some areas, dentists in general practice are helping to provide a special service for children and expectant and nursing mothers by working part-time for the local health and education authority in return for sessional payment, and they

suggest that full advantage should be taken of such help. Authorities should not, therefore, confine their efforts to obtaining dentists for whole-time service, but should, through the Executive Council, seek the co-operation of the Local Dental Committee and of the dentists of their areas in obtaining the help of dentists on a sessional basis. Where appropriate, authorities will no doubt make a direct approach to dentists.

The Ministers desire to commend this matter to the Authority's urgent consideration, and they will be glad if the Authority will make a report not later than September 30th next—a copy of which should be sent to each of them—on the steps which have been taken in pursuance of this circular and of their outcome.

A copy of this circular has been sent to the Medical Officer of Health and School Medical Officer.

OBITUARY

ANDREW ALEXANDER MCWHAN, M.B., B.SC. (P.H.), GLASG., D.P.H.

We record with regret that Dr. Andrew McWhan, who was from 1911 to 1946 Medical Officer of Health for the County of Berwick, died at his home at Cheeklaw, Duns, Berwickshire, on August 6th, 1952. He was born at Linlithgow in 1881 and studied medicine at the University of Glasgow and University College, London, graduating M.B., Glasgow, in 1906, and taking the B.Sc. degree at Glasgow and the conjoint D.P.H. in London in 1909. After a first appointment as assistant M.O.H. and S.M.O. in Fife he was appointed to Berwickshire where he remained for the rest of his career.

He had considerable war service, serving in the South African War as a sergeant in a field hospital. In the 1914-18 war he went overseas with the 2nd Mounted Division, served in Egypt and with the Salonica army in the 22nd Division, and in the Sinai desert as technical adviser on water reconnaissance to G.O.C. Desert Column, and latterly as D.A.D.M.S. Scottish Command. As Major McWhan he was twice mentioned in despatches.

He joined the British Medical Association in 1909, acted as Secretary of the South-Eastern Counties Division from 1923 to 1936; was chairman of the Division for 1938 and was president of the Edinburgh Branch in 1935.

His other activities included membership of the Scottish Council for Health Education and of the Council of the Scottish Branch of the Society of Medical Officers of Health; and he was a Fellow of the Royal Sanitary Institute. He joined the Society of M.O.H. in 1909 and was elected to fully-paid life membership on his retirement.

SOCIETY OF MEDICAL OFFICERS OF HEALTH

NOTICES

INSTALLATION OF PRESIDENT, 1952-53

Dr. Andrew Topping (Dean of the London School of Hygiene and Tropical Medicine) will be installed as President of the Society of Medical Officers of Health for the session 1952–53 by the retiring President (Dr. W. G. Clark) at an ordinary meeting to be held in the Lecture Theatre of the London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, London, W.C.1, on Thursday, September 18th, 1952, at 5.30 p.m. Dr. Topping will deliver his Presidential Address after his installation. At 6.30 p.m. following the installation ceremony, a sherry party has been arranged for those members attending the meeting and for those attending the School Refresher Course which is being held at the London School of Hygiene during that week. The President-elect hopes that as many as can will attend the installation and will remain for the sherry party afterwards. The cost of the sherry party to those attending will be 7s. 6d., inclusive of buffet refreshments. To enable the Central Office to make satisfactory arrangements for this sherry party it is necessary to ask all members of the Society who intend to be present at the meeting and/or the sherry party to notify the Assistant Secretary at the Central Office by the first post on September 10th enclosing with their notice a remittance to cover the cost.

ORDINARY MEETING

Notice is hereby given that an ordinary meeting of the Society will be held in the Lecture Theatre, the London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, London, E.C.1, on Thursday, September 18th, 1952, at 5.30 p.m.

AGENDA

1. Minutes.
2. Correspondence.
3. Installation of Dr. Andrew Topping, M.A., M.D., F.R.C.P., D.P.H. (Dean of the London School of Hygiene and Tropical Medicine), as President of the Society, 1952–53.
4. Vote of thanks to retiring President (Dr. W. G. Clark).
5. Election of Fellows and Associates. (List to be circulated.)
6. Nomination of candidates for election.
7. Presidential Address by Dr. Andrew Topping.
8. Any other business.

By Order,
G. L. C. ELLISTON,
Executive Secretary.

Tavistock House South,
Tavistock Square,
London, W.C.1.
August 11th, 1952.

THE ANNUAL DINNER

The annual dinner will be held on Thursday, October 23rd next, at the Piccadilly Hotel, London, W.1, at 6.45 for 7.15 p.m., with the new President (Andrew Topping, T.D., M.D., F.R.C.P., D.P.H., Dean of the London School of Hygiene and Tropical Medicine) in the chair. The principal guest will be Mr. Iain Macleod, P.C., M.P., Minister of Health.

It is hoped that there will be a large attendance of members and their guests. The charge for tickets will be 25s. each (for those paid for at the time of application up to October 16th): 27s. 6d. each where applications and/or remittances are received after October 16th. This is inclusive of gratuities but not of drinks and cigars or cigarettes. Evening dress with decorations.

Applications for tickets with remittances be sent as early as possible to the Executive Secretary.

County District Group.—A general meeting of the Group will be held in Birmingham on Saturday, September 27th. Details will be circulated shortly to all members of the Group.

REPORTS

THE COUNCIL IN SCOTLAND

By the kind invitation of the President (Dr. W. G. Clark), of the Scottish Branch, and of the Civic Authorities, the July Council meeting was held in the City Chambers at Edinburgh on Friday, July 18th, 1952, and was followed by a short ordinary meeting of the Society on Saturday, July 19th. The two days which the Council spent in Edinburgh were interspersed with several social occasions which were thoroughly enjoyed.

At one o'clock on the Friday, the Council adjourned its business meeting to take luncheon with the Lord Provost and Magistrates of the City. Several of the Council members' ladies were also present. The Lord Provost himself was absent overseas but his place was taken by Baillie Duncan Matthews, who briefly and wittily welcomed the guests, for whom the Chairman of Council (Dr. J. M. Gibson) replied expressing their appreciation of this hospitality. After concluding its meeting in the afternoon the Council, again accompanied by the ladies, attended a cocktail party given by the Chairman of the five Scottish Regional Hospital Boards at the George Hotel. Lord Mathers, of the Scottish South-Eastern R.H.B., and Sir Alexander Macgregor, of the Scottish Western R.H.B., acted as hosts and many other distinguished men associated with medical and hospital services were also present.

On Saturday morning a short ordinary meeting of the Council of the Society was held for the election of new members and was followed by a joint meeting with the Scottish Branch at which Dr. Nora Wattie, the President of the Branch, took the chair. The speaker at this meeting was Sir James Learmonth, who gave a most provocative address, which appeared to have been stimulated by a food infection incurred on the previous day on a visit to London. Sir James raised a number of points on which he thought the clinicians should be given a lead by the preventive service and a lively discussion followed until it was again time to adjourn for luncheon with the Scottish Branch at the Albyn Restaurant. There Dr. Nora Wattie was in the chair and was supported by distinguished representatives of the City and University. She made a charming speech of welcome and the reply for the Council of the Society was made by the President-elect, Dr. Andrew Topping. After luncheon the visitors from the South and some of the members of the Scottish Branch broke up into three parties for a motor-coach tour of Edinburgh and its surroundings. The commentaries on points of interest visited were given by the drivers of the buses, who appeared to have been selected by the Corporation for their skill as expounders of Scottish history. At least one motto for the Public Health Service emerged when the scene of a 19th century collapse of

several houses in the Royal Mile was visited and the story was told of the small boy who cried from under the ruins "Heave awa', lads! We're no' a' deid yet."

The most sincere thanks are due to Dr. Clark, Dr. Wattie and Dr. Riddell (Hon. Secretary of the Scottish Branch) and to the Edinburgh Corporation and to the Chairmen of the Regional Boards for the ways in which they made this a memorable occasion. It was the feeling of all who attended from the South that the Society would be wise not to leave the election of another President from Scotland to too distant a future.

COUNCIL MEETING

A meeting of the Council of the Society was held in the City Chambers, Edinburgh, on Friday, July 18th, 1952, at 10 a.m.

The Chairman (Dr. J. M. Gibson) presided, and there were also present the President (Dr. W. G. Clark), Drs. W. Alcock, F. A. Belam, W. H. Bradley, F. G. Brown, J. S. G. Burnett, T. M. Clayton, H. M. Cohen, H. Kenneth Cowan, C. B. Crane, C. K. Cullen, K. Hart, A. S. Hebblethwaite, C. E. Herington, J. A. Ireland, J. B. McKinney, M. Mitman, J. B. S. Morgan, A. A. E. Newth, A. G. Reekie, J. Riddell, J. A. Stirling, Mr. A. Gordon Taylor, L.D.S., Drs. G. McKim Thomas, Andrew Topping, W. S. Walton, N. Wattie, A. Mower White, H. C. Maurice Williams and J. Yule. Dr. A. V. Kelynack, of the B.M.A., was also present.

171. **Apologies for Absence** were received from: Prof. C. Fraser Brockington, Dr. C. Metcalfe Brown, George Buchan, H. D. Chalke, Sir John Charles, Sir Allen Daley, Drs. F. M. Day, R. H. G. H. Denham, J. Fenton, M. Florentin, F. Gray, R. H. H. Jolly, J. Maddison, Prof. R. H. Parry, Drs. Hugh Paul, R. C. M. Pearson, G. H. Pringle, E. J. Gordon Wallace, C. Leonard Williams, Prof. G. S. Wilson.

It was resolved that a message of goodwill be sent to Dr. C. Metcalfe Brown who had now resumed his duties after his illness.

172. **Whitley Medical Functional Council.**—(i) *Implementation of Industrial Court Awards.*—Dr. Kelynack gave a formal report of the present position regarding the implementation of the two Awards of the Industrial Court. The report showed a much-improved position.

(ii) *Appeals.*—A short report was also submitted on the results of various appeals and on the position with those pending. One important result was the success of the appeal made by the M.O.H. of Bristol County Borough against the way in which the Bristol Corporation had exercised its discretion within the permitted range of salary scales. This result opened up the possibility of further appeals being made where it was considered that an authority had exercised its discretion unfairly or unwisely.

(iii) *Recent Meeting of Committee C.*—Dr. H. Kenneth Cowan submitted a verbal report on the discussions which had taken place at a recent meeting of Committee C regarding the proposed reconsideration of the salary scales for Assistant Medical Officers. It appeared that the Employers Side had turned down a request of the Staff Side for further consideration to be given to this matter, without adequate reason. The Staff Side would consider the question of future action at its next meeting. In this connection it was reported that a resolution had been received from the West of England Branch as follows:—

> "That in any future negotiations concerning conditions of service and salaries, Medical Officers of Health should have representation comparable with that enjoyed by the general practitioner."

A reply had been sent to the Hon. Secretary of the Branch pointing out that both the case for the general practitioners and that presented at the Industrial Court for the Public Health Service were conducted by counsel, that the actual individuals engaged were the same in both cases, except for leading counsel and that this change was only due to the elevation to the bench of the counsel who had conducted the case for officers in the Public Health Service. This reply was confirmed by the meeting.

173. **Dual Appointments.**—A verbal report was submitted by Dr. Kelynack on the present position in the discussions on the remuneration of officers holding dual appointments. A new formula had been considered and forwarded to the Ministry for approval. The Association of Local Authorities had been unwilling to accept the new formula. They had pointed out that they were prepared to renew their original offer of major user salaries to all parties, or of fragmentation for all parties, though they much preferred the idea of the major principle. They could not accept the principle that officers should have applied to them whichever arrangement happened to be more favourable in their particular cases. They undertook to consider as sympathetically as possible what safeguards could be proposed to avoid detriment or prejudice to existing officers bearing in mind the variety of different arrangements which existed at present. It had been agreed that the Ministry of Health should prepare a draft of the proposals considered necessary to safeguard such officers. Such proposals would, of course, have to be agreed by both the Local Authorities representatives and by the representatives of the British Medical Association.

The President informed the meeting that the position in Scotland was that those officers who were engaged for the major part of their time in the Hospital Service remained as full-time officers of the Hospital Board but that those officers who were engaged for the major part of their time by local authorities had their salaries fragmented. The meeting expressed confidence in the attitude which was being taken by the representatives of the Public Health Service.

174. **Durham County Council—Closed Shop.**—Dr. H. Kenneth Cowan, the Chairman of the Joint Emergency Committee of the Professions, submitted a report on a meeting which had been held between representatives of the Professions and of the Durham County Council when the terms of reference in the submission of the dispute to arbitration were decided. It had been agreed that both sides accept the principle that members of the professions employed by the Durham County Council should not be required, as a condition of service, to belong to a professional organisation and that the question to be decided by the Tribunal was whether the requirement of the Durham County Council that application for extended sick leave could only be made through the professional organisations was in conflict with this agreed principle. Dr. Cowan also reported on the hearing of the case and stated that it was anticipated that the Tribunal would very shortly make known its decision.

175. **Mixed Appointments in the Metropolitan Area.**—It was reported that the London County Council had decided to comply with the request of the B.M.A. that the condition of service to which objection had been raised would be removed so that the security of tenure of the officer concerned would no longer be in doubt.

176. **Sanitary Inspectors' Working Party.**—A report on the oral evidence given in support of the Society's written evidence at a recent meeting of the Working Party was received.

177. **School Health Service and General Practitioners and the Transmission of Information from Hospitals to Medical Officers of Health.**—A report was submitted on the conference which had been held between representatives of the Society and of the Public Health, Central Consultants and Specialists, General Medical Services, and Central Ethical Committees of the B.M.A. which had been held to consider the operation of the agreed practice of consultation between officers in the School Health Service and general practitioners and also the question of transmission of information from hospitals to Medical Officers of Health. The Council confirmed the recommendations made at the conference (reported in PUBLIC HEALTH, June, 1952, p. 150).

178. **Medical Manpower in War-time.**—It was reported that the lists of nominees by the Society for consideration by the Society and the Local Authority Associations had now been prepared and were ready for forwarding to the Local Authority Associations.

179. **Public Health Service Representatives on the B.M.A. Council.**—It was reported that Dr. C. Metcalfe Brown had asked that his name be withdrawn from nomination by the Public Health Service representatives for membership on the B.M.A. Council and that in accordance with the previous decision of Council arrangements had been made for the appointment, under B.M.A. By-law 63(2), of Dr. H. Kenneth Cowan in his stead.

180. **Education Act.**—(i) It was reported that the Dental and School Health Service Groups had considered the proposed amendments to the Education Act and had agreed to offer no criticism of the proposals of the Ministry.

(ii) The attention of members was drawn to Ministry of Education Circular 22/52 which emphasised to Education Authorities that there was a requirement in the Education Act that authorities should provide a comprehensive service of free dental inspection and treatment, for school children and other priority classes. It was pointed out that this requirement could not be met by the use of the dental facilities provided under the National Health Service Act and that arrangements must be made by all authorities to maintain a separate service which would form part of the School Health Service.

181. **Status of Medical Officers of Health.**—It was resolved that consideration of the action taken by the Scottish Branch to investigate the conditions of service attaching to the post of C.M.O.H., Kirkcudbright, be referred to the General Purposes Committee.

182. **Industrial Health Service** (*Min.* 148).—A verbal report on a further meeting between representatives of the Society and the Planning Sub-committee of the B.M.A. Occupa-

tional Health Committee was submitted by the President. It had been reported that certain selected Medical Officers had agreed to carry out pilot surveys within the areas of their authorities into the needs for an Industrial Health Service. In one area the survey was to be confined to certain industries being carried on within a large authority and other surveys would include a specified small area of a large industrial centre, a medium-sized provincial town, a rural area, a dock area, and a large group of associated industries. It was agreed that in the case of the provincial town an approach be made to Dr. R. M. Dykes, M.O.H. of Luton, to see if he would be willing to co-operate. Other members of the Society taking part in these pilot surveys were Dr. W. G. Clark, Dr. Stuart Laidlaw, Dr. H. C. Maurice Williams and, it was hoped, Dr. Arnold Brown.

183. **D.P.H. Committee** (*Min.* 149).—The Executive Secretary submitted a verbal report of discussions which had taken place at a further meeting of the D.P.H. Committee held on June 9th.

184. (*a*) **Programme for the Session 1952-53** (*Min.* 150).—It was reported that arrangements had now been made for the installation of the President for the session 1952–53 to take place in the Lecture Theatre in the London School of Hygiene and Tropical Medicine, on Thursday, September 18th, at 5.30 p.m. Dr. Andrew Topping, the President-elect, had suggested that the sherry party for members concerned in the Refresher Course for Medical Officers engaged in the School Health Service, which was to be held at 6.30 p.m. on that day, be extended to include members of the Society present for the installation ceremony. The cost for members would be 7s. 6d. per head inclusive of buffet refreshments. It was agreed that arrangements be made accordingly.

(*b*) **Annual Dinner.**—It was reported that the Hon. Treasurer had agreed that the price of tickets for the annual dinner be fixed at 25s. each (for those paid for at the time of application up to October 16th) or 27s. 6d. where applications and/or remittances are received after October 16th. The action of the Hon. Treasurer was confirmed and it was decided that the list of official guests be considerably reduced and that no toastmaster be engaged.

185. **B.M.A. Subscriptions.**—A letter dated May 20th from Dr. A. S. Hebblethwaite was received, in which it was suggested that representations be made to the B.M.A. for a reduction in subscriptions for the Public Health Service and that it be suggested to the B.M.A. that, if necessary, such members would be prepared to forgo their right to receive free copies of the *British Medical Journal*. It was reported that at the Annual Representative Meeting it had been decided to refer to Council for sympathetic consideration the suggestion that salaried officers of the Public Health Service be allowed a reduced subscription to the B.M.A. Arising from the discussion on this matter, it was resolved to refer to the General Purposes Committee of the Society a suggestion that junior fever clinicians be allowed a reduced subscription should they decide to become members of the Society.

186. **Tuberculosis Regulations** (*Min.* 154).—A report on the effects of the Tuberculosis Regulations prepared by the Medical Officers of six municipal boroughs in the Home Counties, and which contained a recommendation regarding the transfer of information from one local authority to another, was referred to the General Purposes Committee for consideration.

187. **Occupational Resettlement of Tuberculous Persons.**—It was reported that a letter had been received from the B.M.A. suggesting that the Society consider the wording of Ministry of Health Circular 7/52. The Public Health Committee of the B.M.A. had considered this circular and some objection had been made to the fact that the only reference in the circular was to the Medical Officers of Health of local health authorities, whereas Medical Officers of Health of all local authorities should be responsible for carrying out the work suggested in the circular. It was resolved that the B.M.A. be informed that the Society concur with the view taken by the Public Health Committee and that a letter be addressed to the Ministry accordingly. It was reported further that arrangements were being made for discussion to take place on this matter between representatives of the Public Health, Occupational Health and Tuberculosis Group Committees of the B.M.A.

188. **Report of the Central Health Services Council on Co-operation between Hospital, Local Authority and General Services.**—The report was received and it was resolved that a letter be addressed to the C.H.S.C. intimating that the Society was of opinion that a useful purpose would be served by the formation of the co-ordinating committees suggested in the report. It was resolved further that copies of the letter addressed to the C.H.S.C. be forwarded to other interested parties.

189. **Medical Inspection of School Teachers, etc.** (*Min.* 157).—It was reported that the School Health Service Group had considered Ministry of Education Circulars 248 and 249 and Administrative Memorandum 248 and were of opinion that entrants to training colleges should be required to submit themselves to *x*-ray examination of the chest as are the teaching profession. It was resolved that representation be made to the Ministry that students at training colleges be required to submit themselves to a mass-radiography unit for examination during their first year.

190. **B.M.A. Annual Representative Meeting.**—Dr. H. Kenneth Cowan reported briefly on matters of interest to the Public Health Service raised at the A.R.M. of the B.M.A. in Dublin.

191. **Public Health Committee, B.M.A.**—It was resolved that Drs. H. D. Chalke and H. M. Cohen be nominated as representatives of the Society on the Public Health Committee of the B.M.A.

192. **General Practice under the National Health Service** (*Min.* 82).—It was reported that the Society had been asked to send six representatives to attend a meeting of the Central Health Services Council, at 3.15 p.m., on July 30th, to give oral evidence in amplification of the written evidence already submitted. The following members were asked to represent the Society on this occasion: Dr. W. G. Clark, Sir Allen Daley, Drs. C. E. Herington, A. A. E. Newth, J. A. Stirling and H. C. Maurice Williams. The Committee of the C.H.S.C. had forwarded a list of questions on which it was hoped the Society's representatives would give evidence. The meeting discussed the questions at length and suggested the lines on which the representatives would base their replies to the Committee.

193. **Toxic Chemicals Used in Agriculture.**—It was reported that the County Group had been unable to supply any evidence for presentation to the Working Party and the Ministry of Food had, therefore, been informed that the Society had no evidence to present. It was reported that a further letter had been received from the Ministry of Food again inviting the Society to attend a meeting of the Working Party. It was resolved that the question of the persons to represent the Society at a further meeting of the Working Party be left in the hands of the President-elect.

194. **Name of the Society.**—A recommendation passed at a joint meeting of the County and County Borough Groups was considered and adopted. It was resolved that all the necessary steps be taken forthwith to change the name of the Society to "The Society of Preventive Medicine" and that enquiries be made as to the possibility of obtaining a Royal Charter on the occasion of the coronation of Her Majesty Queen Elizabeth II or in 1956 to mark the centenary celebrations of the Society.

196. **Fire Guards.**—A letter, dated May 20th, from the Women Public Health Officers' Association, requesting the Society to give consideration to the possibility of suggesting that local authorities be requested to take steps to obtain and sell suitable fire guards to mothers attending the local authority clinics was received, but it was felt that no action could be taken on this suggestion.

197. **Northern Ireland Superannuation Regulations.**—The attention of members was drawn to the fact that Regulations had now been made to permit and control the transfer of superannuation rights between this country and Northern Ireland.

198. **Public Health Engineering.**—A report from Dr. J. Greenwood Wilson on the post-graduate course in Public Health Engineering organised by the Imperial College of Science and Technology and the London School of Hygiene and Tropical Medicine was received.

199. **Health Control at Airports.**—A letter, dated May 6th, from the Ministry of Health enclosed a copy of a draft circular letter and enclosure which had been agreed with the Department of Health for Scotland and the Ministry of Health and Local Government for Northern Ireland on the question of Health Control at Airports. It was pointed out by the Ministry that the International Sanitary Regulations had now been made and could not be influenced by any recommendation of the Society and that any comments the Society wished to make should be confined to the Regulations which were to be made as a result of the adoption of the International Regulations. It was resolved that the Ministry be informed that the Society could do nothing but accept the position as it was and had no comments to make on the suggestions.

200. **Evacuation of Children.**—A letter, dated June 12th, from the Ministry of Education set out the proposed code for use on medical classification cards to be used in the event of evacuation of school children who present special problems. It was resolved that the question be left with the School Health Service for consideration.

201. **Annual Reports of Medical Officers of Health, of Port Health Authorities and of Riparian Authorities.**—A letter, dated June 21st, from the Ministry of Health requested the observations of the Society on the revised form of report to be used in the annual reports of these authorities and which it was

proposed to introduce shortly. It was resolved that the Ministry be informed that the Society was strongly in agreement with the introduction of the proposed form.

202. **Membership of the Society.**—After consideration of all the relevant details regarding an application for membership of the Society which would be considered at the next ordinary meeting of the Society it was resolved that no objection be raised to the election of the member as a Fellow of the Society.

203. **Distribution of Transferable Deaths.**—A letter, dated June 25th, from the General Register Office encloses a proposed revised memorandum covering the present procedure respecting the distribution of transferable deaths issued for the guidance of Medical Officers of Health. The revised memorandum was considered and it was agreed that the suggestions of the General Register Office be accepted and that no comments be made on the proposals.

204. **Standing Sub-committee for Food Matters.**—It was reported that the Standing Sub-committee for Food Matters was at present considering :—

(*a*) Proposed standards for saccharin tablets.

(*b*) A proposed amendment to the Public Health (Meat) Regulations, 1924–48 which proposes to bring the slaughter of horses, asses and mules, intended for sale for human consumption, into line with the slaughter of other animals.

205. **Maternity and Child Welfare Group.**—It was resolved to refer to the General Purposes Committee a request by the M. & C.W. Group that the name of the Group be changed to "The Maternal and Child Health Group."

206. **Mental Deficiency Legislation.**—It was resolved to refer to the General Purposes Committee consideration of the comments of the School Health Service Group on the National Association for Mental Health's proposals for the amendment of the law regarding Mental Deficiency.

207. **Salaries of Medical Civil Servants.**—A letter, dated July 5th, from the Deputy Secretary of the B.M.A. asked the Society's co-operation in refusing publication of advertisements for Medical Officers in the Civil Service in PUBLIC HEALTH. It was resolved to support the policy of the B.M.A. in this matter.

208. **School Medical Inspection Cards.**—It was noted that the School Health Service Group, in consultation with Dr. Peter Henderson, Ministry of Education, had devised experimental forms 4 HP. which are to be tried out in several areas of the country.

209. **Centenary of the Society.**—It was resolved that a centenary number of PUBLIC HEALTH be issued in 1956 in recognition of the centenary of the foundation of the Society and Dr. W. S. Walton was thanked for undertaking the preparation of this important document.

210. **National Birthday Trust Fund.**—A letter, dated July 5th, from the National Birthday Trust Fund invited the Society to appoint a representative to serve on the Steering Committee to carry out an enquiry into the effects of fatigue upon expectant women who carry on their employment until late in pregnancy. The survey is being sponsored by the National Birthday Trust Fund and the Steering Committee will also comprise a representative from the Royal College of Obstetricians and Gynaecologists and the British Paediatric Association. It was resolved that the Society support this survey and that Dr. Ann Mower White be nominated to serve on the Steering Committee.

211. **Training of Health Visitors.**—The following communication was received from the County Borough Group :—

> The County Borough Medical Officers of Health Group wish to draw the attention of the Society's Council to the serious fall in establishment of health visitors on the staffs of local health authorities. The Group is aware that the Ministry of Health is reticent about setting up a working party on the qualifications, recruitment and training of health visitors until the results of the Nuffield Job Analysis of Public Health Nursing are available, but the County Borough Group regret this delay and would urge the Society to have its own evidence ready and prepared so that the opinion of the Society could be made known to the working party as soon as it is constituted. The Group suggest that some of the following points should be considered in the preparation of "evidence" :—
>
> (*a*) The health visitor as a general practitioner of social medical services.
>
> (*b*) The co-operation of the Health Visiting Service with the general practitioners and hospitals.
>
> (*c*) The revision of present health visitors' establishments in the light of increasing commitments of the service under the National Health Service Act, Section 24.
>
> (*d*) Improvement of the health visitors' salaries of order to give at least equality with nursing officers in comparable experience and responsibility in the Hospital Service.

It was resolved that the following members form a sub-committee to consider the question of the training and future employment of health visitors generally : Prof. C. Fraser Brockington, Drs. J. S. G. Burnett, J. A. Stirling, Marjory Topping, Nora Wattie, and that in the meantime the Executive Secretary endeavour to find out the reason for the delay in the report of the Nuffield Job Analysis of Public Health Nursing.

212. **Representation.**—The following were elected :—

(*a*) *National Housing and Town Planning Conference.*—Southport, October 29th to 31st, 1952, one representative, Dr. J. S. G. Burnett.

(*b*) *Royal Sanitary Association for Scotland.*—Largs, October 20th to 24th, 1952, Dr. W. G. Clark.

(*c*) *National Smoke Abatement Society.*—Annual Congress, Portsmouth, September 24th to 26th, 1952, a nominee of the Chairman.

There being no other business the meeting was declared closed at 4.10 p.m.

ORDINARY MEETING

An ordinary meeting of the Society was held in the Dean of Guilds Court Room, Edinburgh, on Saturday, July 19th, 1952, at 10 a.m.

The chair was taken by the President (Dr. W. G. Clark) and there were also present some 35 members.

The minutes of the ordinary meeting of the Society held on May 1st, 1952, were confirmed and signed.

Election of Life Members.—The following were elected fully-paid Life Members of the Society on the recommendation of their Branches and of the Council :—

Home Counties Branch.—Dr. Rutherford Cramb, formerly M.O.H. Brighton C.B., joined the Society 1922.

North Western Branch.—Dr. James Walker, formerly Deputy M.O.H. Preston C.B., joined the Society 1920.

Scottish Branch.—Dr. G. V. T. McMichael, formerly M.O.H. Paisley Burgh, joined the Society 1913.

Election.—The following candidates, having been duly proposed and seconded, were elected to membership :—

Fellows.—Adamson, John Kenneth, M.B., B.S., M.R.C.S., L.R.C.P. (LOND.); Aston, Elizabeth Oliver, L.M.S.S.A. (LOND.); Braid, Grace Fides Matilda, M.B., CH.B., D.P.H., D.OBST.R.C.O.G.; Coulter, Elizabeth Johnstone, M.B., CH.B. (GLAS.); Fay, Leo, M.D., M.B., CH.B., D.P.H. (LOND.); Gaye, Wilhelmina Norah, M.R.C.S., L.R.C.P., D.P.H. (LIVERP.); Hickson, Violet L. deA., M.R.C.S., L.R.C.P., D.P.H. (WALES); James, Marguerite E. M., M.B., CH.B. (EDIN.), D.P.H.; Linnell, Phyllis Mary, M.B., CH.B. (BIRM.), M.R.C.S., L.R.C.P., D.P.H.; Lowe, Greta, M.B., CH.B. (MANCH.), D.T.M.& H.; McElroy, Robert Samuel, M.B., B.CH., B.A.O., D.P.H., D.T.M. (LIVERP.); Matheson, Kenneth William, M.B., CH.B. (EDIN.); O'Flynn, Patricia Mary, M.B., B.S. (SYDNEY); Paterson, John Thomson, M.B., CH.B. (EDIN.); Pyzik, Michalina Bronislawa, B.D.S. (BRIST.); Richards, Hilda M., M.R.C.V.S. (ENG.), L.R.C.P.; Roberts, Constance Evelyn, M.B., B.S. (LOND.), M.R.S.C., L.R.C.P.; Squires, Dorothy Winifred, L.D.S., R.F.P.S. (GLAS.); Stevenson, Margaret Scott, M.B., CH.B. (EDIN.), D.P.H.; Wales, Elizabeth, M.B., B.S. (LOND.); Walsh, Nannie Christina, M.B., B.CH., B.A.O., D.C.H.; Whitfield, Audrey P., M.B., B.S. (LOND.); Wilson-Murphy, Hannah, M.B., B.CH., B.A.O., D.P.H. (CORK); Woods, Grace E., M.B., B.S. (LOND.), D.P.H., D.C.H.

Associates.—Blumenau, Ernest, M.D.U. (FRANKFURT); Evans, William David Percival, L.D.S., R.C.S. (ENG.); Schrotter, Theresa, M.D. (VIENNA).

The meeting terminated at 10.15 a.m.

EAST MIDLAND BRANCH

President: Dr. J. H. C. Clarke (County M.O.H., Kesteven (Lincs.)).

Hon. Secretary: Dr. J. A. Stirling (M.O.H., Chesterfield M.B.).

A meeting of the Branch was held in the Guildhall, Nottingham, on Thursday, March 13th, the President in the chair and 24 members present.

Dr. Clark paid a high tribute to the late Dr. Killick Millard, a former member of the Branch. He referred to Dr. Millard's great work in public health and to the valuable services rendered by Dr. Millard to the Branch ever since its inception and the members present stood as a token of sympathy and affectionate remembrance.

Dr. E. W. Goodwin, medical practitioner of Leicester, then

(*Continued on page 206*)

gave a talk on the National Health Service, the General Practitioner and the Public Health Medical Officer. He particularly stressed the value of the various services of a Public Health Department and its staff to the General Practitioner and laid emphasis on the fact that mutual goodwill and co-operation with a full interchange of information, together with more personal contacts between everyone, would solve a lot of our present difficulties in the working of the National Health Service Act.

A meeting of the Branch was held in the Education Offices, Nottingham, on Thursday, April 17th, the President in the chair and 18 members present.

Dr. Robert Forbes, Secretary of the Medical Defence Union, gave an address on "Medico-legal problems pertaining to the work of Medical Officers in the Public Health Service." He gave an interesting and most instructive talk which was greatly appreciated by the members present as was shown by the large number of questions asked and the keen discussion which followed his paper.

A meeting of the Branch was held in the Guildhall, Nottingham, on Thursday, May 8th, the President in the chair and 29 members present.

Dr. A. E. Martin, of the Ministry of Health Medical Staff, gave a paper on "Civil Defence and the Medical Officer of Health." He dealt in turn with the medical aspects of Chemical, Biological and Atomic Warfare, going very fully into the matter from all aspects. A large number of questions were asked and a comprehensive discussion followed at the end of which Dr. Clarke expressed to Dr. Martin the appreciation of the members for his paper.

An evening meeting of the Branch was held in the Health Department, Newark, on Thursday, June 12th. The President was in the chair and 26 members were present.

Dr. W. Dodd (Nottingham) opened a discussion on the "Role of the Health Visitor." In a very interesting manner he traced the origin and development of this Service and stressed the reorientation required since the coming into operation of the National Health Service Act. An interesting discussion followed in which various suggestions were made as to liaison between health visitors and other parts of the National Health Service, particularly the general practitioner.

Refreshments were taken at the conclusion of the meeting and Dr. Buchanan was warmly thanked for making such excellent arrangements, both as regards the meeting and the refreshments.

SCOTTISH CHILD HEALTH GROUP

President: Dr. Annie Fulton (M. & C.W. M.O., City of Dundee).

Hon. Secretary: Dr. Nora Wattie (Sen. M.O., M. & C.W., City of Glasgow).

The Annual General Meeting of the Group was held in the Public Health Department, Edinburgh, on Saturday, July 12th, at 11 a.m. The following report on the activities of the Group during the past year was given by the Hon. Secretary.

The session 1951–52 has been a most interesting and successful one. Many new members have joined the Group and the membership now stands at 119, compared with 75 during the previous session.

At the Annual Business Meeting held on July 21st, 1951, Dr. Fulton was re-elected President, with Dr. Doris McWalter and Dr. Dorothy Younie as the two Vice-Presidents. There were some changes in the Council. The members now are Drs. Cuthbert, Leask, Mitchell, Hall, Thomson and Allardyce.

It was decided again to hold two-day meetings and one week-end meeting during the session. In addition, a joint meeting with the Association of School Medical and Dental Officers was also fixed for November 3rd, 1951.

In October the Group visited Westerlea School for Spastics in the morning and in the evening met in the Public Health Department, Edinburgh, and heard an interesting account of the training for occupational therapy carried out at the Astley Ainslie Hospital, its principal, Miss Bramwell, giving the talk.

The joint meeting of the Group and the Association was held in the County Buildings, Stirling, on Saturday, November 3rd, 1951, and it proved a very interesting day. In the morning Dr. D. S. Greig, consulting obstetrician and gynaecologist, gave a most interesting and lucid talk on the Rhesus factor. In the evening Dr. W. A. Parker, consulting physician, and Dr. W. J. Howrie, E.N.T. Registrar, discussed its significance from the point of view of mental retardation and deafness and illustrative cases were shown.

On February 9th, 1952, the Group spent the day at Stobhill Hospital where a clinical meeting had been arranged by Dr. Briggs and Dr. Reilly, consulting paediatrician. Various members of the hospital staff, Dr. Reilly, Dr. Fox, consulting physician, Dr. Ferguson, consulting skin specialist, and Dr. Galloway, consulting surgeon, Dr. Findlay Ford, consulting paediatrician, and Dr. Wallace, consulting paediatrician, all gave short papers and several showed cases.

On May 10th and 11th 25 members of the Group visited Newcastle-on-Tyne. A splendid programme had been arranged by Sir James Spence and his staff and on Saturday evening a dinner was held in the Students' Union. On Sunday the staff of Newcastle motored the Group to Corbridge to see the Roman village. The week-end was voted the most successful the Group has held so far and Sir James Spence, Dr. Miller and other members of the staff had taken a great deal of trouble to arrange the programme.

The office bearers for the coming session 1952–53 were elected as follows :—

President.—Dr. Doris McWalter.

Vice-Presidents.—Dr. Dorothy Younie and Dr. Mabel Mitchell.

Secretary, Treasurer and Council Member.—Dr. Nora Wattie.

Members of Council.—Drs. Allardyce, Fulton, Hall, McLeod, Tait and Thomson.

The Editor regrets that he has to defer to the next issue reports of meetings of the Home Counties, Metropolitan, Northern and West of England Branches, and of the County District and Dental Officers Groups.

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